



Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

**EARLY REFILL
DUR OVERRIDE REQUEST FORM**

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____

DOB: _____ City: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ NPI: _____

City: _____ State: _____ Medicaid ID: _____

Fax: _____ Phone: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's Signature

Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider ID# _____

City: _____ State _____

Phone: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name and Strength: _____ NDC: _____

Quantity/Month: _____ Maximum Qty: _____

Reason for Request

Physician increased the dosing frequency

Physician increased the number of units per dose

New admission to Nursing Home

Extra medication needed to stop or mitigate further morbidity due to acute clinical condition

Explanation:_____

Other, Specify_____

***Supporting documentation must be available in the patient record

Note: No early refill can be authorized if the beneficiary's monthly service limit has been reached.

*The pharmacist should maintain documentation for each early refill override that is obtained from **DOM**.

FOR DOM USE ONLY

Eligibility Verified by:_____

Approved:_____ Denied/Code:_____

From Date:_____ Thru Date:_____

Reviewed by:_____

PA#:_____
